Timothy Waidmann

The Urban Institute

Health as an Economic Concept

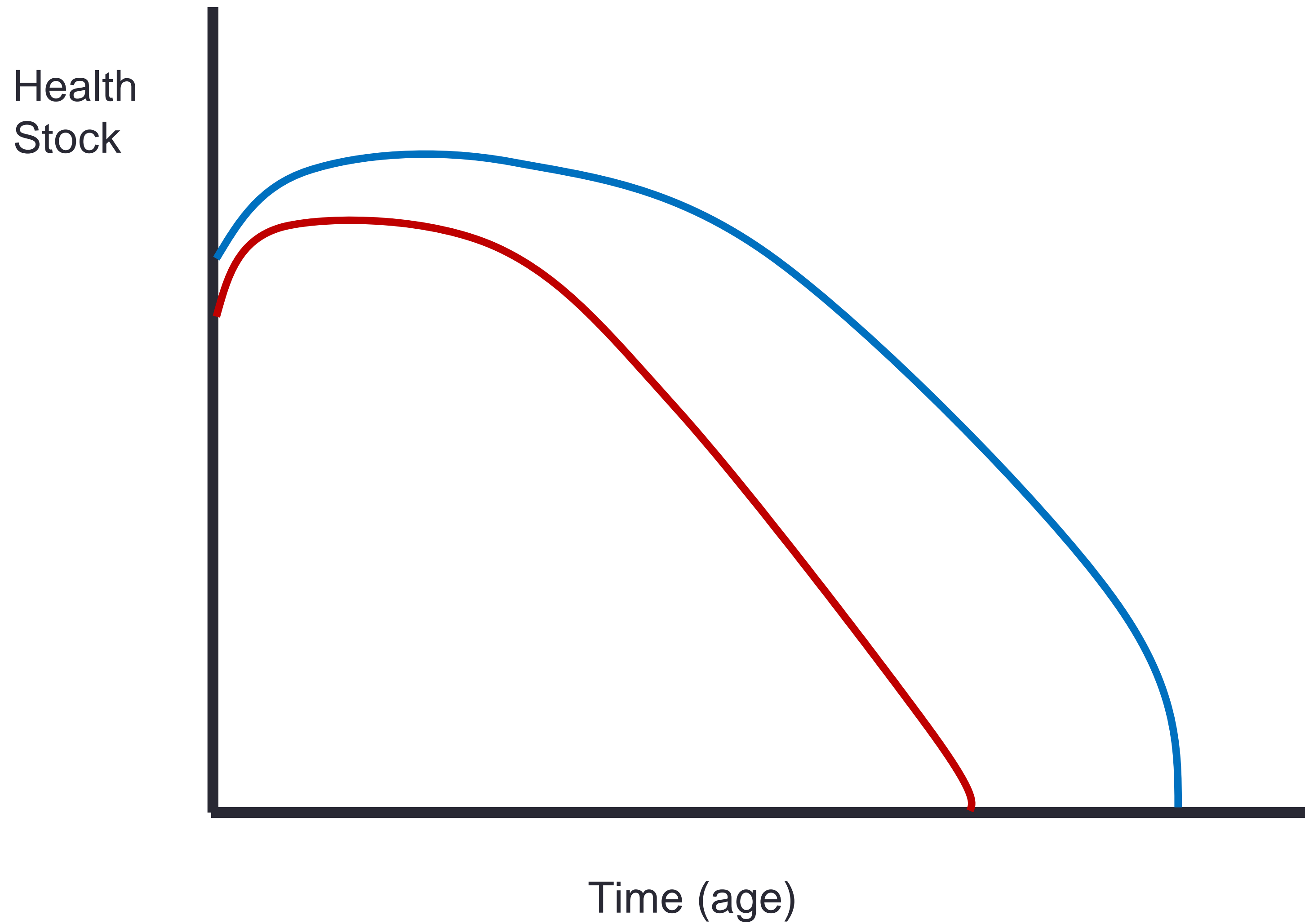
- Humans value it directly (enters our “utility” function as a consumption good)
- We also value it indirectly as a productive asset
  - Part of human capital (like education), necessary to generate income and wealth
  - Value depreciates with time/age
    - Environmental factors
    - Psychosocial Stress
- Can’t really purchase it directly, so we combine/purchase other things to produce it or maintain it
  - Start with varying endowments
  - Medical care
  - Healthy food
  - Exercise

SOURCES OF DISPARITIES

Effects of Deprivation

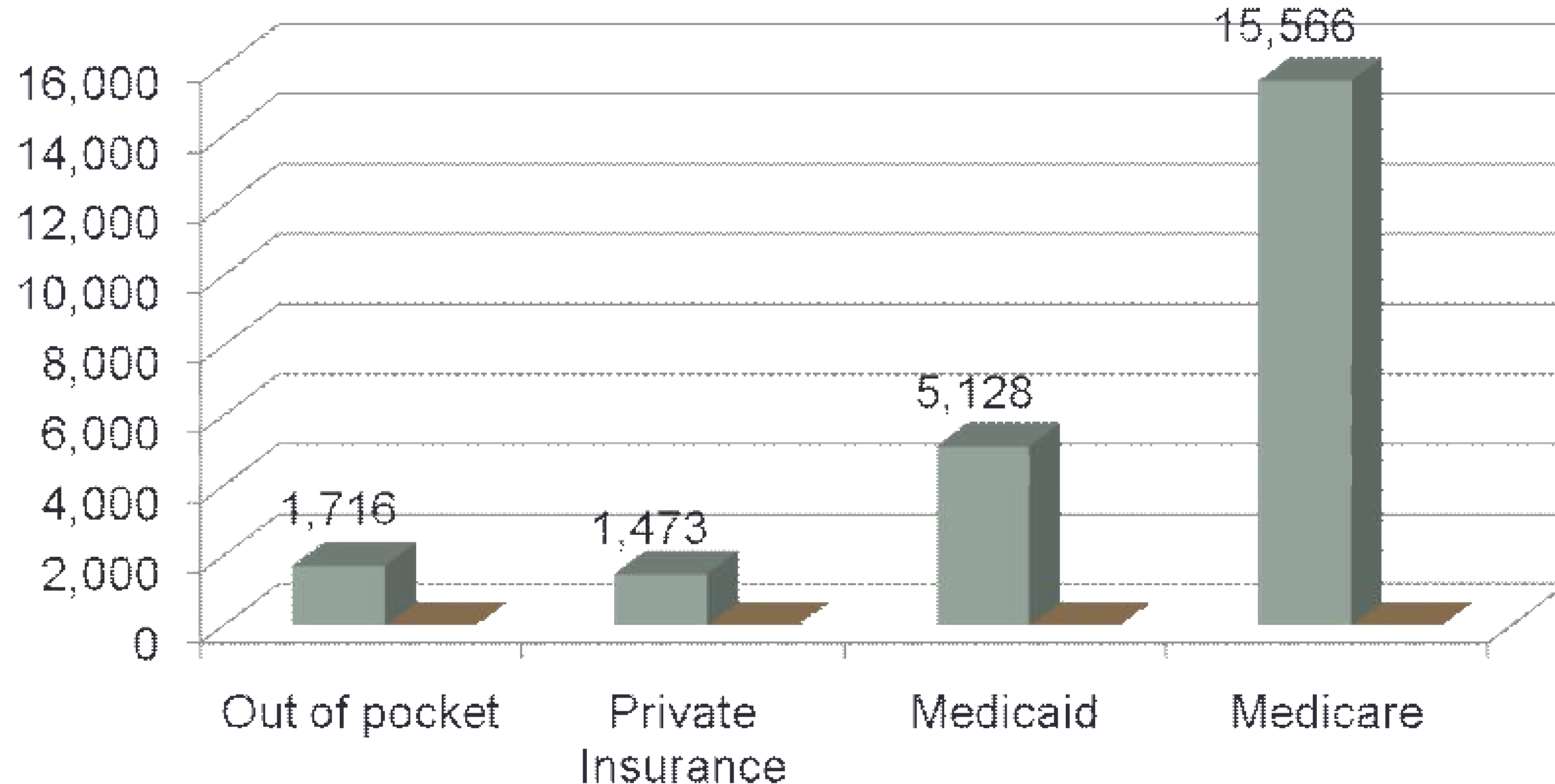
- More external threats to health
  - Pollutants – lead, air & water quality
  - Stress/coping & “weathering”
    - High allostatic load physiologically damaging to cells/organs/systems
  - Rate of depreciation higher
- More difficult to produce/maintain value
  - Lower income makes less health production possible
  - “Price” of restoring/maintaining health is higher
    - Poorer food & fitness environments
    - Insurance coverage disparities
    - Disparities in available health care resources even among insured

Depreciation



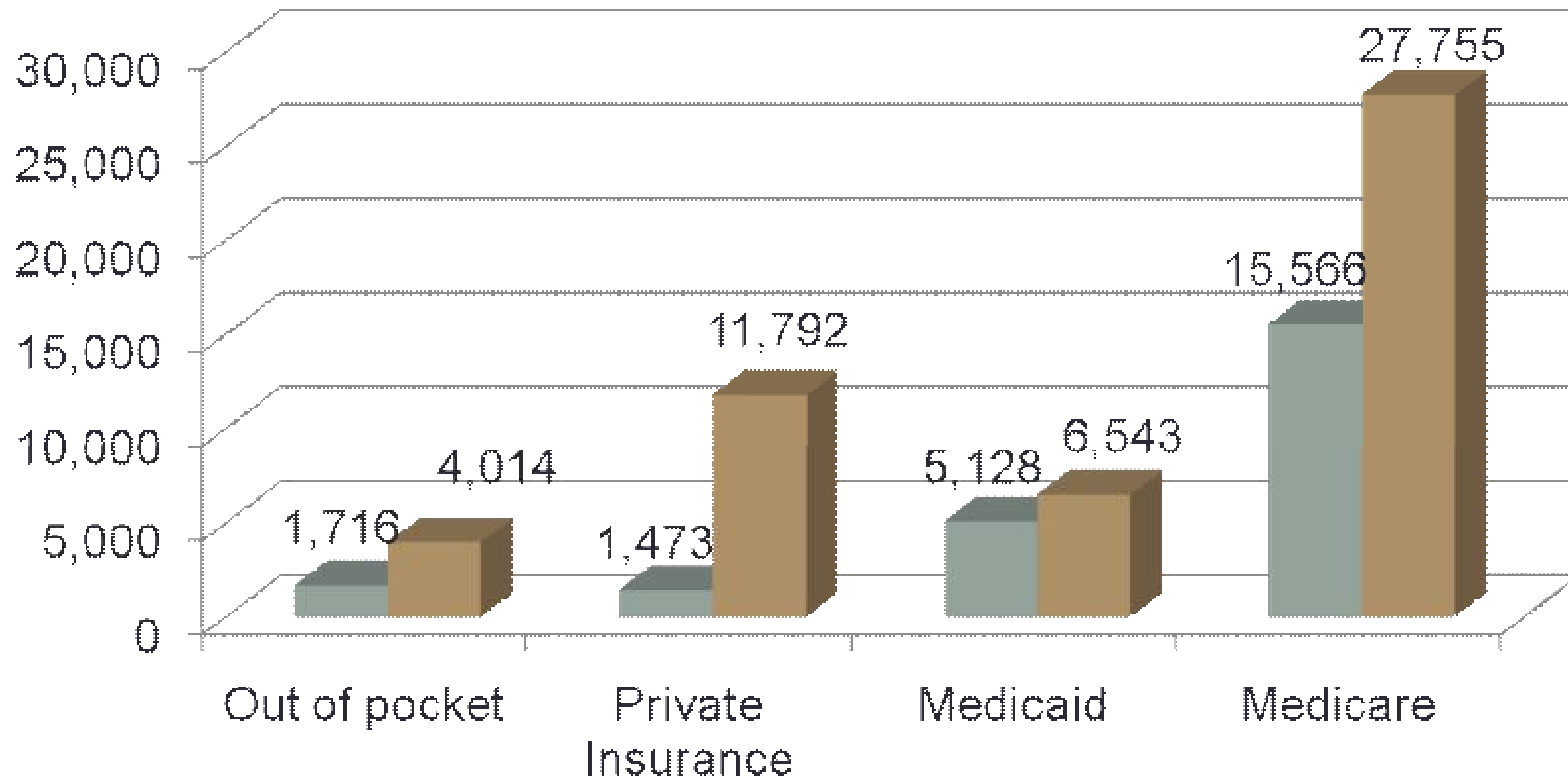
ECONOMIC CONSEQUENCES OF HEALTH DISPARITIES

Estimated excess expenditures



Source: Waidmann (2009), based on Medical Expenditure Panel Survey

Costs will likely grow in future



Source: Waidmann (2009), based on Medical Expenditure Panel Survey

Consequences for Labor Market

- Reduced worker productivity/absenteeism *(LaViest&Gaskin 2009)*
- Health disparities reduce participation in work force
  - For older African Americans and & American Indians/Alaska Natives, health disparities relative to whites account for a significant portion of labor force participation differences *(Bound, Waidmann, Schoenbaum, & Bingenheimer 2003)*
- Disparities increase participation in federal disability programs (DI & SSI). Contributing to higher Medicare and Medicaid costs. But **net** effect is to exacerbate income differentials
- Lower rates of employment also explains some of the differences in private insurance coverage/access to care
  - Contributes to worsening health and increases burden on Medicare if/when folks survive to 65. *(Hadley & Waidmann 2006)*

Effects on other decision making

- Lower rate of return to investments in own health (more needed to produce same maintenance/recovery) less invested
- Spillovers to other decisions as well
  - Reduced health may reduce the rate of return on investments in education, and thus reduce educational attainment
  - Early childbearing as a response to reduced health expectancy

POLICY RESPONSES

- Share of excess costs borne by public health insurance programs suggests federal role
  - Under ACA, exchanges may increase the private incentives, but a big Medicaid expansion may greatly increase government responsibility
  - Larger portion of remaining uninsured likely to be undocumented immigrants, and thus more difficult to address with insurance
- But private employers also bear costs of health disparities, suggesting an incentive to
- Population aging means problems will only get worse
- Not just health insurance/medical care
  - Preventable diseases responsible for large share of cost of disparities, so primary prevention strategies targeted at high risk groups may have greater return
  - Synergy between clinical treatment and community resources suggests investments in improved environment (food/exercise) can increase the rate of return on use of medical care.